Equilibrium (Care) Ltd

Home Instead Senior Care (Slough & Uxbridge)

Inspection report

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Ratings

Overall rating for this service	Good

Is the service safe?	Good
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Good

Summary of findings

Overall summary

Our inspection took place on 19 July 2018 and was announced.

This was our first inspection of the service since the provider's registration

This service is a domiciliary care agency. It provides personal care to people living in their own houses and flats. It provides a service to older people, and people with physical disability, sensory impairment, learning disabilities or dementia.

At the time of our inspection, nine people used the service and there were 15 staff.

The provider is required to have a registered manager as part of their conditions of registration. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. At the time of our inspection, there was no manager registered with us. The manager had applied to register with us prior to our inspection, and was registered shortly after.

People were protected from abuse and neglect. Appropriate systems were in place to safeguard people from the risk of preventable harm. People's care risks were appropriately assessed, mitigated and recorded. We found appropriate numbers of staff were deployed to meet people's needs. People's medicines were safely managed.

The service was compliant with the requirements of the Mental Capacity Act 2005 (MCA) and associated codes of practice. People were assisted to have maximum choice and control of their lives and staff supported them in the least restrictive way possible. The policies and systems at the service supported this practice.

Staff support was very good and ensured workers had the necessary knowledge and skills to provide effective care for people. People's care preferences, likes and dislikes were assessed, recorded and respected.

The service was very caring. There was complimentary feedback from people who used the service and their relatives. People and relatives were involved in care planning and reviews. People's privacy and dignity was respected when care was provided to them.

Care plans were detailed and contained extensive person-centred information. This explained how staff could support people in the right way. We saw there was a complaints system in place which included the ability for people to contact any staff member or the management team. We have made a recommendation about communicating with people effectively in accordance with the Accessible Information Standard.

People, staff and others had very positive opinions about the management and leadership of the service. Staff described there was a good workplace culture. Audits and checks were used to monitor the safety and quality of care. People's equality and diversity was respected, and their human rights were upheld. There was a strong connection between the service and health and social care agencies. We made a recommendation about equality and diversity inclusion in care practices.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

People were protected from the risks of abuse or neglect.

Risk assessments about people's care were completed and regularly reviewed.

There were sufficient staff deployed to meet people's needs

Incidents and accidents were reported and investigated.

Is the service effective?

Good

The service was effective.

People's likes, dislikes and preferences were assessed and used to formulate their care.

Staff received very good support which provided them with the knowledge, skills and experience to provide effective care for people.

People's consent was obtained and the service complied with the requirements of the Mental Capacity Act 2005.

Is the service caring?

Good

The service was caring.

There was positive feedback about the care provided by the staff.

People had developed compassionate relationships with staff.

People were involved in care decisions and regularly asked for feedback.

People's privacy and dignity was respected.

Is the service responsive?

Good

The service was responsive.

People's care was person-centred.

People's communication needs were assessed. We have made a recommendation in relation to the Accessible Information Standard.

People and relatives knew how to make a complaint.

Is the service well-led?

Good

The service was well-led.

People and relatives told us the service was well-led.

There was a positive workplace culture with a credible service ethos. We made a recommendation in relation to equality and diversity inclusion in care practices.

Relevant audits were completed to ensure safe, quality care.

The service worked well with other health and social care partners.

Home Instead Senior Care (Slough & Uxbridge)

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

Our inspection site visit took place on 19 July 2018 and was announced. We gave the service 48 hours' notice of the inspection visit so that the management team would be available.

Our inspection was completed by an adult social care inspector and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service. Our inspector completed the office visit. Our Expert by Experience completed telephone calls to people and relatives.

Our inspection was informed by evidence we already held about the service. We also checked for feedback we received from members of the public, local authorities and clinical commissioning groups (CCGs). We checked records held by Companies House and the Information Commissioner's Office (ICO).

We did not ask the service to complete a Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. The service had a draft PIR prepared, and we used information from their draft as part of our inspection process.

We spoke with two people who used the service and three relatives. We also spoke with the manager and two other staff members. We reviewed five people's care records, two personnel files, medicines administration records and other records about the management of the service.

After our inspection, we asked the manager to send us further documents and we received and reviewed this information. This evidence was included as part of our inspection.

Good

Is the service safe?

Our findings

People and relatives felt the care provided by the service was safe. One relative said, "Absolutely 100% [safe]". One relative explained they had raised a safety concern with the manager. The service appropriately investigated the matter and provided an apology to the person who used the service. Another relative told us, "They [staff] are good at coming up with ideas and give good advice. They have made my life a lot easier; they are caring, mum is safe and I get peace of mind."

Staff understood the processes to follow to safeguard people in their care. Policies and procedures were available and training updates were attended to refresh their knowledge and understanding. Safeguarding training was also included in the induction programme for new staff. The manager recognised their responsibilities and duty of care to raise safeguarding concerns when they suspected an incident or event that may constitute abuse. There were no reported safeguarding events since the registration of the service.

Care risks were satisfactorily assessed and mitigated. This process commenced from the initial enquiry of a person or relative, and continued throughout the package of care. The service collected information from people including the reasons that care was required, pre-existing medical conditions and physical ability. In a person's care documentation, we saw that speech and swallowing, continence, memory and allergies were recorded. There were regular reviews of risk assessments, in consultation with people and their relatives. A face-to-face care consultation took place between the agency and person prior to care being provided. This provided the opportunity to assess risks in the person's home, such as the environment, access and security and moving and handling management.

There were sufficient staff deployed to provide safe care for people. The minimum time for calls was one hour, with sufficient travel time scheduled between the visits. Calls to people's homes were not missed or late. Where the person's care call was not in accordance with the schedule, there were valid reasons why and the person or their relative was informed by the service's office when staff were likely to be behind in the schedule. Live tracking of calls from the office took place, which showed whether there were any deviations from people's care packages. The manager explained how they managed capacity and their plans for development, including the employment of more staff. A relative told us, "I do think there are enough staff. They [the service] pull out all the stops to offer continual care. There's always someone available to cover and they would never leave her [the person] alone.

We reviewed the content of two staff personnel records. We saw that new employee checks for criminal history were made via the Disclosure and Barring Service (DBS). Copies of DBS certificates were available that provided checks were completed at the beginning of staff employment. Other information within personnel files ensured only fit and proper persons were employed by the service. Checks included staff employment history, proof of conduct in prior roles, health declarations and copies of existing relevant qualifications.

The provision of medicines is not a defined part of personal care in the current regulations, however we checked this to ensure people received safe care. The manager was aware of best practice guidance for the

management of medicines in community settings. There was a robust process for the management of medicines. We viewed a person's medicines administration record (MAR). This was produced and printed internally to promote clarity and consistency for care workers because different pharmacies supplied people's medicines. Staff were required to complete medicines competencies to ensure safe administration of medicines.

The manager showed us that infection prevention and control training was completed by staff. Personal protective equipment was provided to care workers. This included disposable gloves, gowns, masks and eyewear.

Incidents and accidents were appropriately reported, recorded and investigated by staff and the manager. Examples we viewed showed that sufficient detail was recorded and that the manager had reviewed the circumstances leading up to the incident, and how to prevent recurrence in the future.

Good

Is the service effective?

Our findings

People's care needs were appropriately assessed to ensure their likes, dislikes and preferences were included into the support they received. We looked at two people's care documentation to check their needs and choices were assessed. There was detailed information about people's likes, dislikes and preferences. A daily routine was formulated for each person. For example, one person's care documentation stated, "Takes a flask [of fluids] to bed with him for when he wakes up." Other examples of people's tailored care included "[The person's] clothes will be ready the night before", "Gets dressed independently" and "[Drinks] preference is a small amount of tea." There was detailed information about people's care routines which ensured staff could provide the most effective care.

Staff were equipped with the necessary skills, knowledge and experience to meet people's needs. One relative told us, "They [staff] are fully trained and one of them tells me how much she loves this job." Staff confirmed that the induction and subsequent training they received prepared them for their role. New staff worked with senior care workers to assist with continued training throughout the induction process, so they could consolidate their learning. Staff did not work independently until they were deemed competent. Standardised training required by the provider was completed, which included Skills for Care's "Care Certificate". However, service-level training and development opportunities were also tailored to individual staff requirements. Staff felt encouraged and supported to increase their skills and gain vocational qualifications. In addition to mandatory courses, staff accessed additional topics to help enhance the care people received. Staff were asked for feedback on all training provided to ensure it was meaningful and effective. Staff participated in regular one-to-one sessions with their managers. 'Touchpoint' telephone calls were made to staff from the office, to ensure staff did not develop work-based isolation.

People were provided with support to eat and drink where this had been identified as part of the care assessment process . The exact level of support a person needed with food and fluids was recorded in the care plans. Staff reported any concerns they had about a dehydration or malnutrition to the office, and subsequent referrals were made to the GP or a dietitian.

Staff provided appropriate support which enabled people to access healthcare appointments, as needed. The service also liaised with health and social care professionals involved in people's care if their health or support needs changed. People's care records included evidence that the service had supported them to access GPs, occupational therapists, physiotherapists and social workers.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. We checked whether the service was working within the principles of the MCA.

Standardised forms were used to record consent for care packages and sharing people's data. We saw that mandatory training for staff included the requirements for consent and the MCA. The manager demonstrated good knowledge of the MCA principles set out in the relevant Codes of Practice. Outcomes of mental capacity assessments and best interest decisions were recorded in care plans. We noted one person's mental capacity assessment lacked detail, and pointed this out. The manager organised to have the form completed in entirety. Where relevant, people's power of attorneys had provided legal consent to the package of care.

Good

Is the service caring?

Our findings

We asked people and relatives for their views about the staff that supported them. Comments included, "Lovely. Really, really good. A few hiccups at first but it all got sorted out" and "The girls [care workers] that come are very good and he [the person] is familiar with them." Positive reviews of the service from 2018 were also available on a popular domiciliary care agency website. Feedback included, "Home Instead is very caring and diligent in their observations of the care required for my mother. They listen and are very helpful at all times. Communication is superb and all caregivers are always on time", "Great office support and great carers. Good feedback when our mother needs extra support" and "We are very pleased with the quality of care provided by Home Instead to my elderly parents. The care providers have treated them with dignity and kindness." The feedback received demonstrated people were treated with kindness, respect and staff had developed positive relationships with them.

We observed office staff on the telephone with people who used the service and relatives. Staff spoke politely with the callers, offered reassurance and referred to them with their names. The staff told us whenever an issue arose around care or if a person or relative had a concern, they were prompt to respond to ensure satisfaction.

Several strategies were used to ensure people received support that was caring and inclusive. This included the completion of regular quality assurance calls and care package reviews. This ensured people and their relatives had the ability to provide feedback, and they received their care in line with their preference. Other methods included the daily team 'huddles'([meetings) between the manager and office staff. People's and relatives' feedback was discussed during the 'huddle' meeting. During staff supervision and training sessions, the management team provided any feedback received from people, their relatives or other professionals involved in their support. The manager told us, "We use this feedback to review and improve the delivery of care and share any learning within the team to promote best practice."

As part of our inspections, we check whether people's independence is maintained and promoted and their level of involvement in decision-making. People and relatives we spoke with explained that the service encouraged independence. One person told us, "Yes, they help me and let me eat in the garden." A relative commented, "Yes, the walks [around the house] and…weekly routine helps." Care documentation recorded how to protect and promote people's independence. This included instructions to staff such as encouragement of people to complete tasks, and only aiding when necessary. There was evidence of people's and relatives' involvement in care planning. The manager wrote, "Care plans are frequently reviewed to meet the changing needs of the individual and always making sure their wishes and feelings are at the forefront of the service we provide."

People and relatives told us the care was dignified and privacy was respected. The manager described the methods care workers used to ensure that they protected people's privacy and dignity. This included closing doors and curtains when delivering support and ensuring that people were covered up during intimate personal care.

Confidential information about people who used the service, staff and others was protected. At the time of the inspection, the provider was registered with the Information Commissioner's Office (ICO), as required. The General Data Protection Regulation requires every organisation that processes personal information to register with the ICO unless they are exempt. We found the service complied with the relevant legislative requirements for record-keeping. Records were secured when not in use. People's, relatives' and staff's confidential information was protected.

Good

Is the service responsive?

Our findings

People told us their care was person-centred. People and relatives told us that the service always took preferences for care and support into consideration. For example, a relative stated, "Yes, I asked for a male carer at bath time and they [the service] agreed, as it's very hard to wash him [the person]." This was a good example of responsive care by the service to ensure the person's personal hygiene needs were met.

Care documentation included useful information for staff so that personalised care was provided. There was a "client profile" which sets out a person's social background and included the past, present and future. For example, the care record for one person stated their mother was French and they loved to talk about France. There was information in the file which enabled staff to hold a meaningful conversation with the person during their personal care. This included various cultural information and "chatty topics" (talking points) about France. The care file notes showed that staff often used this person's background and interest to maintain and improve their emotions and behavioural state.

The service strived to match people with appropriate staff members. This was done my assessing and examining the interests of people, and then allocating staff with similar hobbies and interests. People's cultural, spiritual and social preferences were also discussed. A care worker was assigned to a person based on the identified common factors, however if the person, relative or the service felt it was necessary, a more suitable staff member would be substituted. Staff and people therefore had a good connection which enabled person-centred care.

The service ensured care needs were regularly assessed and any changes were promptly reported and acted on. People and relatives could contact the office or an on-call staff member at any time for support, even outside of their designated support visits. The manager wrote, "Our [staff] are trained to recognise, report, and record changes in the health, well-being and behavioural patterns of clients. Our [staff] report all concerns to the office and ensure they document accordingly…once the care manager is alerted to any concerns they will act appropriately to ensure the client's safety." This assisted to prevent sudden declines in people's health and to prevent unnecessary hospital admissions. People could be provided with appropriate support in their own home rather than in more complex healthcare locations.

All providers of NHS care or other publicly-funded adult social care must meet the Accessible Information Standard (AIS). This applies to people who use a service and have information or communication needs because of a disability, impairment or sensory loss. There are five steps to AIS: identify; record; flag; share; and meet. The service had taken steps to meet the AIS requirements. Staff had not received specific training in the principles of the AIS at the time of our inspection. However, the care documentation clearly showed that the service was identifying and recording communication impairments, and steps were implemented to ensure information was provided to people in a way they could understand it. Care documentation explained what communication aids, such as glasses and hearing aids, people required as part of their daily lives. In one person's file, staff noted a person had difficulty with their memory and this led to risks. Appropriate steps to aid communication with the person were recorded, such as "remind him of his name", "avoid telling [him he] is being repetitive" and "check yesterday's care logs [progress notes]."

We recommend that the service reviews the requirements of the Accessible Information Standard.

People and relatives told us they knew how to make a complaint or raise a concern. There was a satisfactory complaints system in place. This included information for people, relatives and others about how to raise concerns or complaints. A copy of the complaints process, within the service user guide, was accessible to people in their homes. There was a complaints policy, which set out the responsibilities for staff who received, assessed, investigated and responded to complaints. Accompanying the complaints policy was a complaints process. We saw complaints were recorded in a log, and investigations took place which included appropriate communication with the complainant. The manager explained how they dealt with a difficult situation, and that they "Explored options with the [complainant] to ensure the service satisfied their [expectations]."

At the time of our inspection, no one who used the service received end of life care. The service had considered people's end of life choices and preferences, and where relevant had recorded them.

Good

Is the service well-led?

Our findings

People and relatives were complimentary of the service's management. They told us they knew the names and roles of the office staff and the manager. They also explained that they were regularly visited by office staff and the manager. One relative said, "Yes, when the new head of clients started [the manager] bought her over to meet us." People and relatives also said they felt the management listened to anything they had to say. For example, a relative commented, "One carer wanted to start at 6.30am instead of 7am but that was too early. I said 'no'. I spoke with [the manager] and they left it as 7am. A person told us, "Yes, I can call the director [the manager], and he also answers the phone."

Staff told us there was a positive workplace culture that was open, and that the manager was approachable and supportive. One staff member said, "Home Instead Senior Care is a new experience for me. This job allowed me to come out of my shell." Another staff member stated, "The culture of the company is very good. There is good communication with the national office and help is always available when I need it." Other comments from staff included "We always know about any changes [to the service], "We communicate well with each other and can always speak with a manager" and "Caregivers can come into the office and speak to us about anything." We were told of positive support from the management team. For example, a person that was a former service user passed away. Care workers who had previously cared for the person experienced grief when they became aware of the death. One care worker was supported on the phone for two hours, with the team leader providing emotional support and debriefing. The care workers were also provided access to, and reminded of the provider's Employee Assistance Programme, which enabled further confidential support.

The manager told us how they engaged with staff to provide the best possible care and support for people. They said they often referred to the ethos and values of the service during discussions, team meetings, supervisions or chats with staff. The service's values were displayed within the office and on the provider's website. These included the motto "To us, it's personal." The service therefore had a clear, credible strategy for safe and quality care provision. The manager explained they met with the team members regularly, including informal conversations by meeting at a local coffee shop. There was also "cake Fridays", where food was provided each week in the service's office to encourage care workers to drop in and catch up with the staff and manager.

There was an organisational equality and diversity policy, and a human rights policy in place. We discussed with the manager ways to raise staff awareness of the human rights underpinning principles of equality, diversity, dignity and privacy. It was evident that these principles were embedded in practice; people's rights were respected and people were treated equally. The staff we spoke with also reported that the manager protected staff rights, and valued and supported the whole team with their personal development. We explored with the manager how the service could provide care to people from culturally and linguistically diverse backgrounds. There was an example of a person who spoke mainly in their first language, and staff were employed who were fluent in the same language. We asked the manager how the service could provide appropriate care to people with protected characteristics under the Equality Act 2010. They provided example of steps they would take, such as altering a person's care practices and teaching staff new ways of

working.

We recommend that the service examines how equality, diversity and human rights can be implemented for all people's care.

People's care files were well-organised and maintained, and the manager explained how paper and computer-based records were stored and accessed. There was a quality assurance system in place which included audits of people's daily care notes, medicines, personnel files. Areas for improvement were identified, and an action plan was created and feedback given to staff to ensure changes were made. The manager stated this increased the quality of care the service provided. The action plan was regularly reviewed. Regular audits by the provider's head office were conducted, which were thorough and ensured appropriate oversight of the service from a national level. The service was also benchmarked against other services to gauge quality and drive continuous improvement.

The service and manager had a strong community presence and network within the wider adult social care sector. The service used a variety of social media outlets to promote best practice care, current news articles and as an avenue for consultation. There were good connections with the local authority and clinical commissioning group, local NHS England services and a university. The manager was a dementia 'champion' and provided their knowledge and expertise to the local community through various events and initiatives. The connection with other health and social care organisations fostered relevant knowledge and information to be transferred back to the service, and implemented to benefit people's care.